

KENTUCKY DEPARTMENT OF WORKERS CLAIMS
Frankfort, KY 40601

AGREEMENT AS TO COMPENSATION AND ORDER APPROVING SETTLEMENT

Workers' Compensation Claim No. _____

IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.
Every section should be filled in. If a section is not applicable, fill in the blank with N/A.

Claimant	Insurer/Self-Insured/Self-Insurance Group	
Social Security Number	Date of Birth	Insurer's Address
Address	City, State Zip Code	
City, State, Zip Code		
Employer	Other participating parties	
Address	Address	
City, State, Zip Code	City, State, Zip Code	

INJURY

Date: _____ County in which injury occurred: _____
Brief description of occurrence resulting in injury: _____
Nature of injury(ies) including body part(s) affected: _____

MEDICAL INFORMATION

Medical expenses paid: \$ _____ Date of last medical payment: _____
Medical expenses unpaid or contested: \$ _____
Surgery performed: _____ Yes _____ No Nature of surgery: _____
Hospitalization(s): _____ Yes _____ No Length of hospital stay(s): _____

Impairment ratings: (Attach entire medical report that provides ratings)

	Date Given	Physician
_____ %	_____	_____
_____ %	_____	_____
_____ %	_____	_____

Restrictions on activities -- Attach most recent medical report setting forth physical restrictions.
Diagnosis or diagnoses: _____

If medical treatment is continuing, attach a copy of executed Form 113 indicating designated

physician.

WORK INFORMATION

Type of work at time of injury: _____
Average weekly wage at time of injury: \$ _____ Date of return to work after injury: _____
Wages upon return to work: \$ _____ Type of work performed after injury: _____
Type of work performed at time of settlement: _____

BENEFIT AND SETTLEMENT INFORMATION

Amount and duration of temporary total disability paid to date: \$ _____ X _____ = _____
Per week No. of weeks Total

Monetary terms of settlement: \$ _____, to be paid as follows: _____ lump sum, _____ weekly for _____ weeks, _____ by annuity, _____ other _____
Total settlement amount: \$ _____ Percent of permanent disability: _____ %

Settlement computation: _____

Does settlement amount include waiver or buyout of _____ past or _____ future medical expenses?
____ Yes ____ No. If yes, settlement amount for waiver or buyout: \$ _____

If settlement terms provide for lump sum representing weekly benefits greater than \$10, does claimant have an adequate source of income during disability? _____ Yes ____ No

Source of income: _____ Amount: \$ _____

OTHER INFORMATION

If additional information is pertinent to settlement, explain, (Attach additional pages if necessary):

____ Other responsible parties against whom further proceedings are reserved: _____

This the _____ day of _____, 19____.

Attorney or representative for claimant (Signature)

Claimant (Signature)

Attorney or representative for claimant (Name typed)

Attorney or representative for employer

Address

Address

City, State, Zip

City, State, Zip

Attorney for Special Fund

ORDER APPROVING SETTLEMENT AGREEMENT

IT IS ORDERED that the above Agreement as to Compensation be and the same in hereby **APPROVED**.

This the _____ day of _____, 19____.

Arbitrator/Administrative Law Judge